Edit Number	Edit Description
1	BILL PROVIDER/CLAIM TYPE MISMATCH
2	RECIPIENT INELIGIBLE ON DOS
3	CLAIM CURRENTLY IN PROCESS. DO NOT RESUBMIT CT Y
4	BILL PROVIDER NUMBER NOT ON FILE
5	BILL PROVIDER NAME/NUMBER MISMATCH
6	BILLING PROVIDER INELIGIBLE ON DOS
7	PROCEDURE CODE REQUIRES MODIFIER
8	RECIPIENT NUMBER MISSING/INVALID
9	RECIPIENT NAME MISS/INVALID/WITH RECIPIENT NUMBER
10	RECIPIENT INELIGIBLE - UNKNOWN TO INRHODES
11	RECIPIENT NOT ELIGIBLE/AUTO-DENY
12	RECIPIENT NOT ON FILE/AUTO-DENY
13	TOTAL CHARGE MISSING OR NOT EQUAL TO SUM OF DETAIL
19	PATIENT STATUS MISSING/INVALID
20	LAB INDICATOR MISSING/INVALID
22	PRIMARY DIAGNOSIS MISSING OR INVALID
25	ATTEND/PERF PROVIDER NUMBER MISSING
27	SECOND SURGICAL DATE IS MISSING/INVALID/ILLOGICAL
28	THIRD SURGICAL DATE IS MISSNG/INVALID/ILLOGICAL
29	PRIMARY SURGICAL DATE IS MISSING/INVALID/ILLOGICAL
31	SECOND DIAGNOSIS NOT ON FILE
32	THIRD DIAGNOSIS NOT ON FILE
33	FOURTH DIAGNOSIS NOT ON FILE
34	ADMISSION DATE MISSING/INVALID/ILLOGICAL
36	RECIPIENT LEVEL OF CARE MISSING/INVALID
40	FIFTH DIAGNOSIS NOT ON FILE
41	FDOS MISSING/INVALID
42	PATIENT STATUS/DISCHARGE CODE MISSING/INVALID
43	ADMISSION CODE MISSING/INVALID
45	DISCHARGE/THROUGH DOS MISSING/INVALID
46	DISCHARGE/THROUGH DOS MISSING/INVALID
50	MEDICARE COVERAGE INDICATOR MISSING/INVALID
52	DETAIL DIAGNOSIS MISSING/INVALID
53	FROM DOS MISSING/INVALID
54	DETAIL THROUGH DOS MISSING/INVALID
55	DETAIL PROCEDURE CODE NOT ON FILE
56	DETAIL MODIFIER NOT ON FILE
57	DETAIL PROCEDURE CODE NOT VALID FOR DATE BILLED
58	QUANTITY OR UNITS MISSING/INVALID
59	MODIFIER NOT VALID FOR SERVICE DATE BILLED
60	DETAIL CHARGE MISSING/INVALID
61	BILLED DAYS GREATER THAN ONE MONTH
62	MODIFIER AGE RESTRICTION
63	BILLED DAYS GREATER THAN ONE MONTH
64	DETAIL LINE CHARGE MISSING/INVALID

65	PLACE OF SERVICE CODE MISSING/INVALID
66	HCPCS CODE REQUIRED AND MISSING/INVALID
67	PROCEDURE/MODIFIER CODE NOT ON FILE
68	NDC MISSING/NOT ON FILE
72	MAXIMUM QUANTITY LIMIT EXCEEDED
73	DAYS SUPPLY MISSING/INVALID
75	NDC REFILL LIMIT EXCEEDED
77	REFILL NUMBER MISSING/INVALID
80	CLAIM CHECK EDIT SET AT DETAIL
99	NON PDL DRUG REQUIRES AUTHORIZATION
108	REVENUE CODE MISSING/INVALID
109	INVALID REVENUE CODE FOR DIALYSIS CROSSOVER CLAIM
110	RECIPIENT ELIGIBILITY - NO MEDICARE COVERAGE
111	RECIP INELIGIBLE-NO APPROPRIATE PART A/B COVERAGE
112	DETAIL ATTND/PERF PROVIDER INELIGIBLE
113	RECIP INELIGIBLE-NO APPROPRIATE PART A/B COVERAGE
114	RECIP INELIGIBLE-NO APPROPRIATE PART A/B ON DOS
115	MEDICARE PAID DATE MISSING
116	MEDICARE PAID AMOUNT IS GREATER THAN TOTAL BILLED
118	PRIMARY SURGICAL PROCEDURE NOT ON FILE
119	SECOND SURGICAL PROCEDURE NOT ON FILE
120	THIRD SURGICAL PROCEDURE NOT ON FILE
121	STATE FUNDED RECIPIENT NOT ELIGIBLE FOR MEDICAID
122	STATE FUNDED RECIPIENT NOT ELIGIBLE FOR MEDICAID
124	OTHER INSURANCE INDICATOR INVALID
125	OCCURRENCE DATE MISSING/INVALID
127	DTL ACCIDENT/EMPLOYMENT INDICATOR MISSING/INVALID
128	CONDITION/EMPLOYMENT INDICATOR MISSING/INVALID
129	DETAIL ACCIDENT DATE MISSING INVALID
130	FQHC ENCOUNTER CODE MUST BE BILLED ON FIRST DETAIL
131	EPSDT INDICATOR INVALID
132	GENERAL HEALTH LAB PANEL EXCLUDES COMPONENT CODES
133	COMPONENT CODES EXCLUDE GENERAL HEALTH LAB PANEL
134	OBSTETRIC LAB PANEL EXCLUDES COMPONENT CODES
135	COMPONENT CODES EXCLUDE OBSTETRIC LAB PANEL
136	HEPATITIS FUNCTION PANEL EXCLUDES COMPONENT CODES
137	COMPONENT CODES EXCLUDE HEPATITIS FUNCTION PANEL
138	HEPATITIS LAB PANEL EXCLUDES COMPONENT CODES
139	COMPONENT CODES EXCLUDE HEPATITIS LAB PANEL
140	LIPID LAB PANEL EXCLUDES COMPONENT CODES
141	COMPONENT CODES EXCLUDE LIPID LAB PANEL
142	ARTHRITIS LAB PANEL EXCLUDES COMPONENT CODES
143	COMPONENT CODES EXCLUDE ARTHRITIS LAB PANEL
144	TORCH ANTIBODY LAB PANEL EXCLUDES COMPONENT CODES
145	COMPONENT CODES EXCLUDE TORCH ANTIBODY LAB PANEL
146	THYROID LAB PANEL EXCLUDES COMPONENT CODES

147	COMPONENT CODES EXCLUDE THYROID LAB PANEL
148	THYROID LAB PANEL EXCLUDES COMPONENT CODES
149	COMPONENT CODES EXCLUDE THYROID LAB PANEL
154	ABORTION SURGICAL PROCEDURE
155	CLAIM WILL REPROCESS W/ PROC CODE ON 05/30/2006
156	DETAIL ABORTION PROCEDURE
164	SEALANTS ONLY COVERED OCCLUSAL SURFACE/CERTAIN TTH
165	TOOTH SURFACE INVALID
169	PRESCRIPTION NUMBER MISSING
180	TOTAL DAYS GREATER THAN ELAPSED DAYS
201	IF DEA ST ONLY FND RECIP NEED PA FOR DAY/HOME CARE
203	RECIPIENT INELIGIBLE FOR SERVICES BILLED
204	INPATIENT PSYCHIATRIC CLAIM REQUIRES PRIOR AUTH
205	INPATIENT ELECTIVE CLAIM REQUIRES PRIOR AUTH
206	RECIPIENT OVER TWENTY YEARS REQUIRES PRIOR AUTH
207	DETAIL PROCEDURE CODE REQUIRES PRIOR AUTHORIZATION
208	SURGICAL PROCEDURE REQUIRES PA
209	RECIPIENT OVER TWENTY YEARS REQUIRES PRIOR AUTH
210	NUMBER OF DAYS NOT EQUAL UNITS RURAL HEALTH & FQHC
211	AMBULANCE MODIFIER NOT ON FILE
212	THIS SERVICE REQUIRES A MODIFIER
213	PROCEDURE/AMBULANCE MODIFIER CODE NOT ON FILE
214	NDC REQUIRES PA FOR RECIP OVER 20 YEARS OF AGE
215	AMBULANCE MODIFIER NOT VALID F/ DOS BILLED
230	PROGRAM REQUIRES REVIEW OF SERVICES
240	CLAIM DENIED. RESUBMIT WITH NAT"L PROCEDURE CO
241	CLAIM SUSPENDED - PROGRAM INDICATOR BLANK - HEADER
243	CLAIM SUSPENDED - PROGRAM INDICATOR BLANK - DETAIL
244	NO PROGRAM INFORMATION FOR DRUG
250	PROVIDER NOT AUTHORIZED FOR SERVICE BILLED
259	QUANTITY EXCEEDS BENEFIT LIMIT
261	INITIAL DISPENSING LIMITED TO 7 DAY SUPPLY FOR LTC
262	INCREASED DISPENSE FEE DUE TO LTC RESTOCKING
300	SIXTH DIAGNOSIS NOT ON FILE
301	SEVENTH DIAGNOSIS NOT ON FILE
302	EIGHTH DIAGNOSIS NOT ON FILE
303	NINTH DIAGNOSIS NOT ON FILE
304	SIXTH DIAGNOSIS/AGE MISMATCH
305	SEVENTH DIAGNOSIS/AGE MISMATCH
306	EIGHTH DIAGNOSIS/AGE MISMATCH
307	NINTH DIAGNOSIS/AGE MISMATCH
308	SIXTH DIAGNOSIS/SEX MISMATCH
309	SEVENTH DIAGNOSIS/SEX MISMATCH
310	EIGHTH DIAGNOSIS/SEX MISMATCH
311	NINTH DIAGNOSIS/SEX MISMATCH
313	PROVIDER TYPE CSLA PROCEDURE RESTRICTION

314	PROVIDER TYPE LEA MUST BILL WITH MODIFIER
315	PROVIDER TYPE LEA MODIFIER RESTRICTION
316	DAYS SUPPLY NOT WITHIN DAYS SUPPLY MINIMUM/MAXIMUM
342	SERVICE MUST BE SUBMITTED TO HEALTH CARE PLAN
343	ENCOUNTER CODE MUST BE BILLED ON FIRST DETAIL
350	PROCEDURE IS A NON-COVERED GPA SERVICE
351	NDC IS A NON-COVERED GPA SERVICE
352	NON-COVERED GPA SERVICE
390	DETAIL BILLED AMOUNT GREATER THAN $10,000
391	DETAIL BILLED AMOUNT EXCESSIVE VARIANCE
392	AVAILABLE EDIT NUMBER - WAS A VARIANCE CANCEL
393	LAB DETAIL BILLED AMOUNT EXCESSIVE VARIANCE
394	AVAILABLE EDIT NUMBER - WAS VARIANCE CANCEL
395	PHARMACY DETAIL BILLED AMOUNT EXCESSIVE VARIANCE
398	MORE THAN 19 EDIT ERRORS
399	CLAIM PAST 365 DAY LIMIT, W/QUALIFYING ATTACHMENT
400	RECIPIENT HAS PART A COVERAGE ON DOS
401	RECIPIENT HAS PART B COVERAGE ON DOS
402	RECIPIENT HAS PART A COVERAGE ON DOS
403	CLAIM PAST 365 DAY FILING LIMIT, NO ATTACHMENTS
404	CLAIM PAST 365 DAY LIMIT, W/QUALIFYING ATTACHMENT
405	MEDICARE PD DTE > 365 DAYS, APPROVAL ATTACHED
406	CLAIM PAST 365 DAY FILING LIMIT, NO ATTACHMENTS
407	REFERRED TO PHYSICIAN MISSING/INVALID
408	RECIPIENT HAS OTHER INSURANCE ON DOS
409	TOOTH NUMBER MISSING/INVALID
410	DETAIL OVERLAPPING ELIGIBILITY
411	OVERLAPPING ELIGIBILITY/DOS
412	RECIPIENT NOT REGISTERED FOR CEDARRS/DOS
413	ER TIME LIMIT EXCEEDED
414	EMERGENCY OUTPATIENT ACCOMMODATION CODE
415	REFERRING PROV MUST BE CFC FOR RECIPIENT ON DOS
416	MEDICARE PAID DATE > 365 DAYS,NO APPROVAL ATTACHED
417	LOCK-IN RECIPIENT
420	LOCK-IN RECIPIENT - DETAIL
421	NO PER DIEM RATE ON FILE
422	REFERRING PHYSICIAN INFORMATION MISSING
423	RECIPIENT NOT ELIGIBLE FOR DEA SERVICES BILLED
424	RECIPIENT NOT ELIGIBLE FOR MR/DD WAIVER ON DOS
425	RECIPIENT NOT ELIGIBLE FOR PARI WAIVER ON DOS
426	NDC/AGE MISMATCH
427	RECIPIENT NOT ELEGIBLE FOR SDC WAIVER ON DOS
428	RECIPIENT NOT ELIGIBLE FOR A&D WAIVER ON DOS
429	NDC REQUIRES PRIOR AUTHORIZATION
430	UNAUTHORIZED PROCEDURE FOR PROVIDER
431	DME CANNOT BILL PLACE OF SERVICE (INPAT, OUTPAT)

432	POS INPAT/OUTPAT NOT THERAPY/CHIROPRACTIC
433	MANUAL PRICING - NO PRICE ON FILE
434	DIAPER CODE INCONSISTENT WITH WAIVER SEGMENT
435	PHYSICIANS CANNOT BILL TECH COMPONENT/LAB PROC
436	LAB SPECIALTY ONLY MAY BE PAID FOR CYTOLOGY
437	POS INPAT/OUTPAT X-RAY BILL WITH PROF MODIFIER
438	MULTIPLE SURGERY REQUIRES REVIEW
439	MODIFIER REQUIRES MANUAL PRICING
440	NOT AUTHORIZED FOR THIS RECIPIENT LEVEL OF CARE
441	DETAIL MODIFIER 1 ON REVIEW
442	MODIFIER 1 IS NON-COVERED
444	RECIPIENT NOT ELIGIBLE FOR WAIVER SERVICES
445	HDR ATTND/PERF PROVIDER WRONG ORG TYPE
446	DTL ATTND/PERF PROVIDER WRONG ORG TYPE
448	ATTND/PERF PROVIDER INELIGIBLE
449	MHRH RECIPIENT NOT ELIGIBLE ON DOS - HEADER
450	MHRH RECIPIENT NOT ELIGIBLE ON DOS - DETAIL
451	COMPOUND DRUG REQUIRES INDIVIDUAL INGREDIENTS
452	NO PRICE ON FILE FOR REVENUE CODE
453	ZERO ALLOWED AMOUNT
454	NO PRICE ON FILE FOR PROVIDER
455	PROCEDURE EXCEEDS UNITS ALLOWED
456	PROCEDURE CANNOT HAVE LESS THAN TWO UNITS BILLED
457	RECIPIENT NOT ELIGIBLE/NON-CONTINUOUS NURSING HOME
458	BILLING PROVIDER NOT ELIGIBLE/CONTINUOUS NRSG HOME
459	AMBULATORY SURGICAL RATE NOT ON FILE
460	RECIPIENT/PROVIDER AGE MISMATCH
461	PRIMARY DIAGNOSIS/SEX MISMATCH
462	SECONDARY DIAGNOSIS/SEX MISMATCH
463	DETAIL DIAGNOSIS/SEX MISMATCH
464	DIAGNOSIS/AGE MISMATCH
465	SECONDARY DIAGNOSIS/AGE MISMATCH
466	DETAIL DIAGNOSIS/AGE MISMATCH
467	MEDICARE COVERED SERVICE ONLY
468	THIRD DIAGNOSIS/AGE MISMATCH
469	FOURTH DIAGNOSIS/AGE MISMATCH
470	PROVIDER TYPE/PROVIDER SPECIALITY MISMATCH
471	NO PRICE ON FILE FOR MODIFIER
472	REVENUE CODE MISSING/INVALID
473	REVENUE CODE/PROCEDURE CODE COMBINATION INVALID
474	FIFTH DIAGNOSIS/AGE MISMATCH
475	PROCEDURE NEEDED TO PRICE LAB REVENUE
476	THIRD DIAGNOSIS/SEX MISMATCH
477	FOURTH DIAGNOSIS/SEX MISMATCH
478	FIFTH DIAGNOSIS/SEX MISMATCH
479	NO CONVERSION FACTOR RATE ON FILE

480	ATTND/PERF PROVIDER NOT ELIGIBLE MEMBER OF GROUP
481	NO MEDICARE RECIPIENT ELIGIBILITY SEGMENT ON FILE
482	NO LEVEL-4 RATE ON FILE
483	ZERO ALLOW AMOUNT/PRICING
485	PROCEDURE CODE ON REVIEW
486	PROVIDER/CLAIM TYPE ON REVIEW, DETAIL PAY
487	PROVIDER/CLAIM TYPE ON REVIEW, HEADER PAY
488	SURGICAL PROCEDURE CODE ON REVIEW
489	RITESHARE EMPLOYERS CANNOT RECEIVE CLAIMS PAYMENT
490	NO DRUG RATE ON FILE
491	GAP IN BILLED DAYS/SPLIT MONTH CLAIM
492	PROVIDER/RECIPIENT COMBINATION NOT AUTH/X6000
493	MHRH CLAIMS REQUIRES FULL MONTH REHAB SEGMENT
494	RECIPIENT DOES NOT HAVE VALID SEGMENT ON FILE/X600
495	MHRH RECP DOESN"T HAVE VALID SEGMENT ON FILE/X6000
496	RECIPIENT DOESN"T HAVE VALID SEGMENT ON FILE/X0339
497	MHRH RECP DOESN"T HAVE VALID SEGMENT ON FILE/X0339
498	CLAIM DOES NOT MATCH RECIPIENT REHAB LEVEL
499	MHRH CLAIM DOES NOT MATCH RECIPIENT REHAB LEVEL
500	CLAIM DOES NOT MATCH RECIPIENT REHAB LEVEL/X6000
501	EXACT DUPLICATE CLAIM
503	SUSPECT DUPLICATE CLAIM
504	NO MEDICARE UCR RATE ON FILE
505	RECIPIENT REHAB PERCENTAGE NOT ON FILE
506	DETAIL DIAGNOSIS ON REVIEW
509	MHRH CLAIM DOES NOT MATCH RECP REHAB LEVEL/X6000
510	INVALID PRICING ACTION CODE
511	INVALID PROVIDER PRICING INDICATOR
514	RECIPIENT NOT AUTHORIZED AS HIGH ACUITY FOR DOS
515	PROCEDURE CODE X6000 HAS TO BE A FULL MONTH
516	MUST HAVE IFA BEFORE BILLING FOR FAMILY CARE PLAN
517	FMLY CARE PLN REV OR FMLY PLN DEVLP MUST BE PAID
519	MAX CASE RATE $50.00 PER CALENDAR MONTH
520	HOSPITAL MUST BE PAID PRIOR TO PRIMARY SURGEON
521	PRIMARY SURGEON PAID PRIOR TO ASST SURG OR ANESTHS
522	CEDARR PRICING PROCEDURE CODE LIST
525	INPATIENT CLAIM $75,000 PER HOSPITAL ADMISSION
526	INFORMATIONAL ONLY-NURSING HOME CLAIM IN PROCESS
527	CHILD CARE PROV HAS NO MANAGED CARE ENROLLMENT DOS
528	NON COVERED SERVICE FOR CHILD CARE PROVIDER
529	NON COVERED SERVICE CHILD CARE PROVIDER - DETAIL
530	SUSPECT DUPLICATE NURSING HOME/HOME HEALTH
531	SUSPECT DUPLICATE NURSING HOME/INPATIENT, HOSPICE
532	SUSPECT DUPLICATE OUTPATIENT/HCFA
533	SUSPECT DUPLICATE OUTPATIENT/INPATIENT
534	SUBSEQUENT DETAIL PRIOR AUTH RECYCLE

535	ONLY ONE NICU REVENUE CODE PER CLAIM
536	REV/PROC MUST BE BILLED WITH INFORMATIONAL DETAILS
537	PROVIDER/BILL TYPE/REVENUE CODE MISMATCH
538	BILLING PROVIDER/PROCEDURE CODE MISMATCH
540	NICU REV CODE MUST BE BILLED ON FIRST DETAIL ONLY
541	NICU PROC CODE MUST BE BILLED ON FIRST DETAIL ONLY
542	NICU INPATIENT SERVICES UNDER REVIEW
543	EARLY REFILL ALERT
544	THERAPEUTIC DUPLICATION ALERT
545	NO CORRESPONDING CLAIM; PLEASE RESUBMIT
546	DRUG TO DRUG INTERACTION ALERT
547	ALERT GENDER CONFLICT
548	SERVICE NOT ALLOWED FOR MANAGED CARE RECIPIENT
549	SERVICE NOT ALLOWED FOR MANAGED CARE RECIPIENT
552	MANAGED CARE OVERLAPPING ELIGIBILITY-HEADER
553	MANAGED CARE OVERLAPPING ELIGIBILITY-DETAIL
554	PROCEDURE NOT ALLOWED FOR RITE START RECIPIENT
555	SERVICE NOT ALLOWED FOR MANAGED CARE RECIPIENT
556	SERVICE NOT ALLOWED FOR RITE START RECIPIENT
557	PROCEDURE NOT ALLOWED FOR MANAGED CARE RECIPIENT
558	PROCEDURE NOT ALLOWED FOR RITE START RECIPIENT
559	RECIPIENT NOT ELIGIBLE FOR SERVICE
560	BILL TYPE/PROCEDURE MISMATCH - SOBRA
561	RECIPIENT OR PROVIDER INELIGIBLE - SOBRA
562	RECIPIENT/PROVIDER MISMATCH ON DELIVERY DATE-SOBRA
563	TYPE OF PREGNANCY OUTCOME INVALID - SOBRA
564	FIRST TYPE OF DELIVERY INVALID - SOBRA
565	SECOND PREGNANCY OUTCOME/DELIVERY INVALID - SOBRA
566	THIRD PREGNANCY OUTCOME/DELIVERY INVALID - SOBRA
567	PREGNANCY OUTCOME NOT ELIGIBLE FOR SOBRA <20 WKS
568	GESTATION AGE INVALID - SOBRA
570	SOBRA ELAPSED DAYS EXCEEDED-UPDATE CAPITATION
571	ALL COMPOUND INGREDIENTS MISSING/INVALID
572	COMPND SEG MUST BE PRESENT WHEN COMPND IND=2
575	MAXIMUM DOSE ALERT
576	MINIMUM DOSE ALERT
577	LATE REFILL
580	FQHC IN-HOSPITAL EXCEPTION NOT VALID PLAC OF SVC
581	FQHC VISION/PODIATRY EXCEPTION INVALID PLC SVC
582	RECIPIENT HEADER ELIG-TDOS GREATER THAN DEATH DATE
583	RECIPIENT DETAIL ELIG-CLAIM DOS > THAN DEATH DATE
591	TERMINATED NDC, TRY ALTERNATIVE
592	DESI DRUG, NDC NOT COVERED
593	NDC NOT COVERED, DRUG CLASS NOT COVERED
594	NON-REBATEABLE NDC, TRY ALTERNATIVE
595	NDC REMOVED FROM MARKET, TRY ALTERNATIVE

596	DO NOT PAY, NO PRICE ON FILE
600	PHARMACY CLAIM/DATE OF SERVICE GREATER THAN 7/1/94
601	OTHER INSURANCE CARRIER CODE MISSING/INVALID
602	PROC MEDICARE/MEDICAID INDICATOR EQUAL TO ZERO
603	PROCEDURE CODE MEDICARE COVERED SERVICE ONLY
605	PROVIDER/PROCEDURE ON REVIEW
606	PROVIDER/DIAGNOSIS ON REVIEW
607	AGE CONFLICT ALERT
608	PROVIDER/DIAGNOSIS ON REVIEW
610	PROVIDER/REVENUE CODE ON REVIEW
611	PROVIDER/NDC ON REVIEW
614	RECIPIENT NOT ELIGIBLE FOR SERVICES
615	QDWI/SLMB RECIPIENT INELIGIBLE FOR SERVICES
616	REVENUE CODE MEDICARE COVERED SERVICE ONLY
617	PROCEDURE CODE MEDICAID COVERED SERVICE ONLY
618	REVENUE CODE MEDICAID COVERED SERVICE ONLY
619	QMB RECIPIENT INELIGIBLE FOR SERVICES
620	QMB RECIPIENT NOT ELIGIBLE FOR SERVICES
623	COMPOUND DRUG - BILL INGREDIENT NDC"S
624	NDC NOT COVERED
625	MUST BE PARTICIPATING PROVIDER W/PRIMARY INSURER
626	NO LTC AUTH ON FILE FOR DOS BILLED > 60 DAYS OLD
627	RPL MISMATCH BETWEEN CLM & LTC AUTH > 60 DAYS OLD
628	PROV MISMATCH BTWN CLAIM & LTC AUTH > 60 DAYS OLD
629	GAP IN BILLED DAYS/SPLIT MO. CLAIM > 60 DAYS OLD
630	OBSOLETE PRICING ACTION CODE
631	NON-COVERED SERVICE/PAC 9
632	NON-COVERED SERVICE/PAC 8
634	BILL PROVIDER CANNOT DISPENSE ORAL CONTRACEPTIVES
635	RPL SUBMITTED NOT VALID FOR PROVIDER
636	NO LONG TERM CARE AUTH ON FILE FOR DATE OF SERVICE
637	RPL MISMATCH BETWEEN CLAIM AND LONG TERM CARE AUTH
638	PROVIDER MISMATCH - CLAIM AND LONG TERM CARE AUTH
639	OPTOMETRY BILL PROVIDER CANNOT BILL L1 MODIFIER
640	ENCOUNTER CLAIM MUST HAVE MORE THAN ONE DETAIL
641	NURSE PRACTITIONER INELIGIBLE BILLING PROVIDER
642	DRUG NOT DISPENSED TO NURSING HOME RECIPIENT
643	SURG PROC CODES SEQUENCED BY DATES OF SERVICE
644	FOURTH SURGICAL PROCEDURE NOT ON FILE
645	FIFTH SURGICAL PROCEDURE NOT ON FILE
646	SIXTH SURGICAL PROCEDURE NOT ON FILE
647	FOURTH SURGICAL DATE MISSING/INVALID/ILLOGICAL
648	FIFTH SURGICAL DATE MISSING/INVALID/ILLOGICAL
649	SIXTH SURGICAL DATE IS MISSING/INVALID/ILLOGICAL
650	DETAIL DIAGNOSIS REQUIRES PRIOR AUTHORIZATION
651	DRUG QTY/DAYS SUPPLY LESS THAN MINIMUM QUANTITY

652	RECIPIENT MID EQUAL TO ZERO
653	PROVIDER NUMBER EQUAL TO ZERO
654	PODIATRY SVCS NOT ALLOWED FOR MEDI NEEDY >= 21 YRS
655	PROCEDURE NOT ALLOWED FOR MEDICALLY NEEDY >= 21YRS
656	NEWBORN CLAIMS BILLED UNDER MOTHER"S ID
657	HOME HEALTH AIDE MINIMUM ONE HOUR PER DOS
658	HEADER DIAGNOSIS REQUIRES PRIOR AUTHORIZATION
659	BILLED DAYS GREATER THAN WORKING DAYS PER MONTH
660	RECIPIENT ELIGIBILITY-HEADER
661	ANESTHESIA PROVIDER REQUIRES MODIFIER
662	MAX UNITS FOR SPAN BILLING
663	PROCEDURE/MODIFIER REQUIRES PRIOR AUTHORIZATION
664	HEADER BILLING PROVIDER REQUIRES PRIOR AUTH
665	DETAIL BILLING PROVIDER REQUIRES PRIOR AUTH
666	BILLED QUANTITY NOT WITHIN RX MINIMUM/MAXIMUM
667	DME PROCEDURE NOT ALLOWED FOR LTC RECIPIENT
668	PAYABLE THROUGH DME PROGRAM
670	RECIP HAS OTHER INS ON DOS-HDR PD/HDR SET
671	RECIP HAS OTHER INS ON DOS-HDR PD/DETAIL SET
672	RECIP HAS OTHER INS ON DOS-DETAIL PD/HDR SET
673	RECIP HAS OTHER INS ON DOS-DETAIL PD/DETAIL SET
674	OTHER INSURANCE AMOUNT MISSING/INVALID
675	PROVIDER TYPE INCONSISTENT WITH BILL TYPE
676	BILL TYPE INCONSISTENT WITH LONG TERM CARE AUTH
677	BILL TYPE INCONSISTENT WITH LTC AUTH > 60 DAYS
678	REVENUE CODE INCONSISTENT WITH PROVIDER TYPE
679	DETAIL DIAGNOSIS POINTER INVALID (PAPER ONLY)
680	PRIOR AUTHORIZATION CUTBACK/MULTIPLE PA
684	CLM BILLED WITHOUT HEADER CLAIM ADJUSTMENT SEGMENT
685	CLAIM BILLED FOR RITESHARE COPAY- SUSPEND
686	ADJ RSN FOR RITESHARE RECIP BILLED MORE THAN ONCE
687	ADJ RSN FOR RITESHARE RECIP BILLED MORE THAN ONCE
693	BILL CO-PAY AMOUNT FOR RITESHARE RECIPIENTS
694	RECIPIENT NOT ENROLLED IN RITESHARE FOR DOS BILLED
695	RECIPIENT PARTIAL ENROLLMENT IN RITESHARE FOR DOS
696	PAYMENT MUST BE COLLECTED FROM OTHER INS CARRIER
697	OTHER COVERAGE CDE INCONSISTENT W/OTHR PAYER AMT
698	INVALID OTHER COVERAGE CODE
699	OTH INS DID NOT PAY.PLS SUBMIT ON PAPER FOR REVIEW
700	PROCEDURE/SEX MISMATCH
701	DETAIL PROCEDURE/SEX MISMATCH
702	SURGICAL PROCEDURE/AGE MISMATCH
703	PLACE OF SERVICE/SURGICAL PROCEDURE MISMATCH
704	PROVIDER TYPE/PROCEDURE MISMATCH
705	PROVIDER SPECIALTY/PROCEDURE MISMATCH
706	PROCEDURE/DIAGNOSIS MISMATCH

708	DETAIL DIAGNOSIS CANNOT BE E CODE
709	DETAIL PROCEDURE/AGE MISMATCH
710	DETAIL PLACE OF SERVICE/PROCEDURE MISMATCH
711	BILLING PROVIDER TYPE/PROCEDURE MISMATCH
712	BILLING PROVIDER SPECIALTY/PROCEDURE MISMATCH
713	DETAIL PROCEDURE/DIAGNOSIS MISMATCH
714	HEADER PRIMARY DIAGNOSIS CANNOT BE E-CODE
715	TAD CONTROL AND STACKING
716	HOSPICE AND HOME HEALTH PROV TYP/PROC CDE MISMATCH
717	OVERRIDE NOT ALLOWED
718	DISPENSE BRAND NAME
719	OTHER INSURANCE PAID GREATER THAN ZERO
720	RECIPIENT NOT ELIGIBLE FOR ASSISTED LIVING WAIVER
721	PROVIDER NOT AUTHORIZED TO BILL NON-MA EI RECIPIEN
723	SYSTEM TIMEOUT EDIT
725	DUPLICATE PAID PRESCRIPTION
726	NDC NOT ALLOWED FOR POS DEVICE
727	TTL UNITS/DAYS BILLED DOES NOT MATCH ORIG RX QTY
728	PARTIAL FILL INFORMATION MISSING OR INVALID
729	PRIOR PARTIAL FILL NOT FOUND
730	INVALID POS SUBMITTER PROVIDER ID
731	LEA CLAIM WITH J1-J8 AID CATEGORY RECI[PIENTS
732	LEA CLAIM WITH J1-J8 AID CATEGORY RECIPIENTS
733	INVALID INTENDED DAYS AND/OR QTY
739	DOUBLE CHECK FOR AUDIT CLAIMS
748	CHEST X-RAY/26 LIMITED ONE PER 365 DAYS, ANY PROV
749	CHEST X-RAY/TC LIMITED ONE PER 365 DAYS, ANY PROV
750	CHEST X-RAY LIMITED TO ONE PER 365 DAYS, ANY PROV
752	HOME HEALTH FIRST HOUR LIMITED ONCE PER DOS
755	HOME HEALTH ADDITIONAL TIME LIMITED PER DOS
795	PRE-OP SRV NOT ALLOWED WITHIN ONE DAY OF SURGERY
796	POST-OP SRV NOT ALLOWED AFTER SURGERY
797	SURGERY NOT ALLOWED WITHIN ONE DAY OF OFFICE VISIT
798	ONE SURGERY ALLOWED PER SAME DATE OF SERVICE
799	PAID OUTPATIENT SURGERY FOR SAME DATES OF SERVICE
801	ANESTHESIA SERV LIMITED TO ONCE PER DAY PER PROV
802	ENCOUNTER VISITS LIMITED TO ONE PER DAY PER PROV
803	LIMIT PROCEDURE TO 5 PER 30 DAYS PER PROVIDER
804	LIMIT PROCEDURE TO ONE/DAY/SAME DIAGNOSIS ANY PROV
806	PROCEDURE LIMITED TO ONCE PER 280 DAYS ANY PROV
807	PROCEDURE LIMITED TO TWO PER 365 DAYS
810	LIMIT VISUAL ANALYSIS TO ONE PER 730 DAYS ANY PROV
811	ORAL EXAM LIMITED - TWO PER CALENDAR YEAR
812	LIMIT PROCEDURE TO ONE PER 730 DAYS ANY PROVIDER
813	LIMIT PROCEDURE TO TWO PER 730 DAYS ANY PROVIDER
815	LIMIT PROCEDURE TO ONE PER DAY PER PROVIDER

816	GENERAL PSYCH LIMITED TO TWO VST PER DAY/UNDER 21
817	LIMIT ECHOCARDIOGRAPHY W/NO MOD - ONE PER DOS
818	DME RENTALS LIMITED TO PURCHASE PRICE
819	LIMIT ECHOCARDIOGRAPHY W/ 26 MOD - ONE PER DOS
820	LIMIT ECHOCARDIOGRAPHY W/TC MOD - ONE PER DOS
830	TOTAL OB SERVICE CANNOT BE BILLED WITH PARTIAL OB
832	INITIAL CONSULT LIMIT TO ONE PER DIAG PER PROVIDER
834	DAY HOSP EXCLUDES CHEMO, GROUP, PSYCHO AND DAY TRT
835	NORPLANT LIMITED TO ONCE IN 5 YEARS
837	ENTERNAL SUPPLIES LIMITED TO $220 PER 30 DAYS
841	PARTIAL OB SERV CANNOT BE BILLED WITH TOTAL OB
843	PRENATAL VISITS LIMITED TO 15 PER 280 DAYS
847	WEEKLY RADIATION THERAPY MGMT LIMIT TO 5 UNT/7 DAY
848	NEW PATIENT VST LMT TO ONE PER LIFETIME/BILL PROV
857	TOTAL PAYMENT FOR PARTIAL OB NOT EXCEED TOTAL OB
859	ROUTINE NEWBORN CARE LIMIT TO ONE PER PREGNANCY
860	NEWBORN RESUSCITATION LIMITED TO ONE PER PREGNANCY
864	ONE OFFICE VISIT PER DAY PER PROVIDER
868	PARTIAL AND COMPLETE CANNOT BE BILLED SAME DOS
869	ALLERGY TESTING LIMITED TO ONE UNIT PER DOS
871	ALLERGY VACCINES LIMITED TO ONE UNIT PER DOS
876	NOT BILL NEWBORN ADMIT WITH SUBSEQUENT HOSP VISITS
877	LIMIT DISPOSABLE UNDERPADS PER 30 DAYS
878	GENERAL PSYCH LIMITED TO ONE VISIT PER DAY/OVER 21
881	SA REHAB VISITS LIMITED PER 365 DAYS
882	DAY HOSPITAL IS LIMITED TO EIGHT UNITS PER DAY
889	NOT BILL SUBSEQUENT HOSP VISIT WITH NEWBORN ADMIT
900	SOBRA CLAIM LIMITED ONCE PER 140 DAYS
901	LIMIT DIAPER CODES PER 30 DAYS
902	LIMIT LINERS PER 30 DAYS
905	DUPLICATE LOCAL CDE TO NAT"L CDE SUBMITTED FOR DOS
909	ADMISSIONS ARE EXCLUDED FROM OB HOSPITALIZATIONS
910	OB HOSPITALIZATIONS EXCLUDE ADMISSIONS
916	REFRACTION LIMITED TO ONCE PER 730 DAYS
925	MH/REHAB EMERGENCY CARE PER 30 DAY VISIT LIMIT
926	PRESCRIBER IDENTIFICATION MISSING/INVALID
927	STERILE GAUZE PADS LIMITED TO 200 PER 30 DAYS
932	CEPHALOMETRIC X-RAY LIMITED TO ONCE IN 730 DAYS
940	INIT ORAL EXAM LIMIT ONE PER PROV PER LIFETIME
941	ORAL EXAM LIMITED - TWO PER CALENDAR YEAR
943	RADIOGRAPHS LIMIT ONE PER 1460 DAYS/SAME PROVIDER
944	INTRAORAL FILMS LIMITED PER DOS, SAME PROVIDER
946	MANAGEMENT LIMIT ONE METHOD PER DOS, SAME PROVIDER
947	PANORAMIC FILM LIMIT ONCE PER 1460 DAYS
948	PROPHYLAXIS LIMITED - TWO PER CALENDAR YEAR
949	RESTORE PIN LMT FOUR PINS PER TTH PER 365 DAYS

953	PULPOTOMY LIMIT TO ONE PER DECIDUOUS TTH/LIFETIME
954	ROOT CANAL LIMITED ONE PER TOOTH/LIFETIME
955	APICOECTOMY LIMITED TO ONE PER TOOTH PER LIFETIME
961	UPPER DENTURE LIMITED TO ONE PER FIVE YEARS
962	LOWER DENTURE LIMITED TO ONE PER FIVE YEARS
963	ROOT EXTRACTIONS/ONE PER TOOTH PER LIFETIME
964	EXTRACTIONS LIMITED TO ONE PER TOOTH PER LIFETIME
972	CATHETERS AND TRAYS LIMITED TO 30 PER 30 DAYS
973	NON STERILE GAUZE PADS/SPONGES LMT 200 PER 30 DAYS
974	KLING TYPE BANDAGES LIMITED PER 30 DAYS
975	STERILE GAUZE/SPONGES LIMITED TO 200 PER 30 DAYS
976	OSTOMY BAGS/POUCHES LIMITED PER 30 DAYS
979	ANTIEMBOLISM STOCKINGS LIMITED TO 12 PER 365 DAYS
980	SHEEPSKIN LIMITED TO TWO PER 365 DAYS
982	DENTAL VISITS LIMITED TO FIVE PER 30 DAYS
984	FQHC ENCOUNTER LIMITED TO FIVE PER 30 DAYS
985	PORTABLE OXIMETER MONITOR RENT LIMITED PER 30 DAYS
986	DENTAL SEALANTS LMT TO ONCE PER PERM TTH/UNDER 21
987	ADULT ANNUAL EXAM LIMITED TO ONE PER 365 DAYS
988	ADHESIVE TAPE LIMITED PER 30 DAYS
990	RECIPIENT ALLOWED MAXIMUM OF 124 UNITS IN 183 DAYS
991	MAINTENANCE RATE MAXIMUM OF 124 UNITS IN 183 DAYS
992	INITIAL CONTACT RATE ALLOWED 1 PER 245 DAYS
993	CASE MANAGEMENT LIMITED TO $600 PER CALENDAR MONTH